PATIENT FINANCIAL AGREEMENT AND ACKNOWLEDGEMENT OF OFFICE POLICIES

Schertz Vision Source is committed to provide you with the best available vision and medical care. We believe that part of good health care practice is to establish and communicate an office and financial policy to our patients.

1. **PAYMENT** is expected at the time of your visit. We accept cash, check, Visa, Mastercard, Discover, American Express, Apple Pay, Google Pay, and Care Credit. Payment will include any unmet deductible, co-insurance, co-payment amount, and charges not covered by your insurance company. All non-filed services are expected to be paid at the time of service.
2. **INSURANCE**: We are participating providers with most insurance plans. We will file all of the claims for these plans. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. As a courtesy to our patients, we will verify your insurance coverage, however, our verification is not a guarantee of benefits payable by your insurance.** In the event your insurance denies the services provided, you will be responsible for the payment in full. If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral prior to your visit in our office to be covered under your medical insurance. If you do not have a valid referral and still wish to be seen, you will be asked to pay for the visit out of pocket in full. **In order to bill your insurance and to meet filing guidelines we do ask for a copy of your insurance card and a photo ID.**
3. **RETURNED CHECKS** will incur a $50.00 service charge.
4. **AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS**: I hereby authorize **Schertz Vision Source** to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to **Schertz Vision Source** all payments otherwise payable to me for **Schertz Vision Source** services.
5. **CONSENT AND DISCLOSURES**: I voluntarily consent to medical treatment for myself and/or my dependents.
6. **RELEASE OF INFORMATION**: I hereby authorize and direct **Schertz Vision Source** to release (verbally or in writing) confidential medical information to any person, entity, government agencies, insurance carriers, or others who are financially liable to **Schertz Vision Source** for charges for medical treatment, and for quality management, utilization review, transfer of medical care, and follow up purposes. I understand that a copy of this document may be used with the same effectiveness as an original.
7. **DIVORCED PARENTS OF PATIENTS**: By signing below, **the adult who signs in a minor child to our practice on the day of service accepts full responsibility for payment.** It is not our policy to send bills or records to the other parent/guardian for the issue of payment or communication. We will communicate about treatment and payment with the parent present at the time of visit. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.
8. **NO SHOW POLICY**: We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than a 24-hour notice. **Patients who do not show up nor provide 24-hour notice are considered a NO SHOW and will be charged a $30 NO SHOW fee.**
9. **PROFESSIONAL SERVICES** are non-refundable including but not limited to contact lens fitting, in-office testing and the **Optomap®**

I have read and understand the practice's office and financial policies and I agree to be bound by its terms.

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Patient's Name Date Signature of Patient/Guarantor, if applicable